UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM

OXANDRIN (oxandrolone)

Patient name:_____Medicaid ID #:_____

Prescriber Name:_____Prescriber NPI#:_____ Contact person:_____

Prescriber Phone#:_____Extension/Option:_____ Fax#:_____

Pharmacy:_____Pharmacy Phone#:_____Pharmacy Fax #:_____

Requested Medication:_____Strength:_____Frequency/Day:_____

All information to be legible, complete and correct or form will be returned

_____

_____

FAX DOCUMENTATION FROM PROGRESS NOTES OR A LETTER OF MEDICAL NECESSITY TO 855-828-4992

CRITERIA:

First 60 day trial period:

- Age ≥ 18 years
- Body Mass Index < 20. Please provide current height, weight and BMI.
- Please describe the patient's nutritional intake. Patient must receive at least partial nutrition orally.
- Please describe concurrent therapies for weight gain (Oxandrin is not approved for monotherapy).

Authorization after 60 day trial. (May approve for an additional 4 months):

- All above criteria remain effective (age, BMI, nutrition and pertinent concurrent therapies).
- Weight needs to have been maintained or has increased. Please provide current height, weight and BMI.
- If weight has not maintained, Oxandrin will not be re-authorized.
- If weight is maintained or has increased, the patient may remain on Oxandrin.

INITIAL AUTHORIZATION:

60 day trial. If weight is maintained or has increased, an additional 4 months may be approved.

REAUTHORIZATION:

6 Months